SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Filing at a Glance

Company: Family Life Insurance Company

Product Name: 2010 Medicare Supplement Plans M & N	SERFF Tr Num: WAKE-126646836	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 45823
Sub-TOI: MS08I.010 Plan M 2010	Co Tr Num: AMHFLMSMN2010AR	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Authors: Toni Hess, Katlyn Gorman, Michelle Miller, Ben Cohen	Disposition Date: 06/01/2010
	Date Submitted: 05/28/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date: 06/01/2010

State Filing Description:

General Information

Project Name: Family Life
Project Number: AMHFLMSMNAR
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 06/01/2010

Deemer Date:
Submitted By: Toni Hess
Filing Description:
Medicare Supplement Insurance Policies

Plan M – Form Number MSIAM201006 AR
Plan N – Form Number MSIAN201006 AR
Outline of Coverage - Form Number MSOCA201007 AR

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 05/26/2010
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 06/01/2010
Created By: Toni Hess
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Application - Form Number MSAPP201004 AR

Wakely Actuarial Services, Inc. is filing the above-captioned forms on behalf of Family Life Insurance Company. A letter of authorization is included for reference. We are requesting the Department's review and approval of this filing.

The Company had Plans A, B, C, D, F and G approved by the Department on January 5, 2010 under SERFF File WAKE-126367724 and have determined they would also like to offer Plans M and N.

The outline being submitted reflects the rates and benefit charts for all of the plans.

The application also reflects the addition of these two plans.

Agents licensed in your state will market these plans to consumers.

The actuarial memorandum and rates are also included with this filing.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration in the review of this filing for Family Life Insurance Company.

Company and Contact

Filing Contact Information

Toni Hess, Compliance Consultant	toni.hess@hesscc.com
931 Clarmont Avenue	215-485-2582 [Phone]
Bensalem, PA 19020	

Filing Company Information

(This filing was made by a third party - WAS01)

Family Life Insurance Company	CoCode: 63053	State of Domicile: Texas
P.O. Box 924408	Group Code:	Company Type: Life and Health
Houston, TX 77292-4408	Group Name:	State ID Number:
(800) 877-7705 ext. [Phone]	FEIN Number: 91-0550883	

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Retaliatory?	No
Fee Explanation:	2 X $50 PER POLICY 1 X $50 PER RATE 3 X $50 ADDT'L FORM
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	$300.00	05/28/2010	36885796

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	06/01/2010	06/01/2010

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Disposition

Disposition Date: 06/01/2010
Implementation Date: 06/01/2010
Status: Approved-Closed
Comment: This approval is subject to the following:

• Increases will not be given more frequently than once in a twelve-month period;

• Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Authorization Letter	Accepted for Informational Purposes	Yes
Form	Medicare Supplement Plan M	Approved	Yes
Form	Medicare Supplement Plan N	Approved	Yes
Form	Application	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Advertising	Approved	Yes
Rate	AR Rates	Approved	Yes

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Form Schedule

Lead Form Number: MSIAM201006 AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 06/01/2010	MSIAM201006 AR	Policy/Contract/Fraternal Certificate	Medicare Supplement Plan M	Initial		49.200	MSIAM201006 AR.pdf
Approved 06/01/2010	MSIAN201006 AR	Policy/Contract/Fraternal Certificate	Medicare Supplement Plan N	Initial		49.300	MSIAN201006 AR.pdf
Approved 06/01/2010	MSAPP201004 AR	Application/Enrollment Form	Application	Initial		44.000	MSAPP201004 AR.pdf
Approved 06/01/2010	MSOCI2006R	Outline of Coverage	Outline of Coverage	Initial		41.300	MSOCI20106R AR.pdf
Approved 06/01/2010	FLBRA 4-10	Advertising	Advertising	Initial		40.600	FLBRA 4-10.pdf

FAMILY LIFE INSURANCE COMPANY

P.O. Box 924408, Houston, Texas 77292-4408

MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN M

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

P.O. Box 924408
Houston, Texas 77292-4408
800-877-7703

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

CAUTION

POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

THIS IS A NON-PARTICIPATING POLICY

TABLE OF CONTENTS

POLICY SCHEDULE

INSURED: [John Doe]

POLICY EFFECTIVE DATE: [07/01/2010]

POLICY NUMBER: [123456]

ISSUE AGE: [65]

SEX: [Male]

STATE OF ISSUE: Arkansas

MODE AT ISSUE: [Annual]

MODAL PREMIUM: [$XXXX]

PREMIUM TERM: [Annual]

UNDERWRITING CLASS: [Preferred]

SPOUSE DISCOUNT: [No]

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN M

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse, parents, grandparents, children, or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the fist sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period;

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits For Plan M

Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (100th) day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000).

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

EXTENSION OF BENEFITS

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstituted policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

EXCLUSIONS

We will not pay benefits for:

(a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
(b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
(c) that portion of any expense incurred which is paid for by Medicare;
(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
(e) services for which a charge is not normally made in the absence of insurance; or
(f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

GENERAL POLICY PROVISIONS CONTINUED

OTHER INSURANCE WITH US: You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted there from.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

This Policy is signed for Family Life Insurance Company by its President.

President

Secretary

FAMILY LIFE INSURANCE COMPANY

P.O. Box 924408, Houston, Texas 77292-4408

MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN N

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US

READ YOUR POLICY CAREFULLY

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

IMPORTANT NOTICE: Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

P.O. Box 924408
Houston, Texas 77292-4408
800-877-7703

POLICY EFFECTIVE DATE AND CONSIDERATION

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION

CAUTION

POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT

THIS IS A NON-PARTICIPATING POLICY

TABLE OF CONTENTS

POLICY SCHEDULE

INSURED: [John Doe]

POLICY NUMBER: [123456]

SEX: [Male]

MODE AT ISSUE: [Annual]

PREMIUM TERM: [Annual]

POLICY EFFECTIVE DATE: [07/01/2010]

ISSUE AGE: [65]

STATE OF ISSUE: Arkansas

MODAL PREMIUM: [$XXXX]

UNDERWRITING CLASS: [Preferred]

SPOUSE DISCOUNT: [No]

TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN N

DEFINITIONS

Benefit Period means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

Calendar Year means the period of time beginning on January 1 and ending on December 31 of that same year.

Coinsurance Amount means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

Hospital means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

Hospitalized or **Hospitalization** means being confined in a Hospital on an inpatient basis.

Immediate Family means Your spouse, parents, grandparents, children, or siblings, and their spouses.

Injury means a bodily injury which is the direct result of an accident and independent of all other causes.

Lifetime Inpatient Reserve Days means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

Medicaid means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family

Policy Effective Date means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

Sickness means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

The benefits paid under this Policy will not duplicate benefits paid by Medicare.

Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period;

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits For Plan N

Medicare Part A Deductible: Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21st) day through the one hundredth (100th) day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000).

Medicare Part B Expenses: Coverage for:

1. The lesser of twenty dollars ($20) of the Medicare Part B coinsurance or co-payments for each covered health care provider office visit (including visits to medical specialists); and

2. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if admitted to any Hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

EXTENSION OF BENEFITS

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstituted policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

EXCLUSIONS

We will not pay benefits for:

(a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
(b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
(c) that portion of any expense incurred which is paid for by Medicare;
(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
(e) services for which a charge is not normally made in the absence of insurance; or
(f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

REINSTATEMENT: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

NOTICE OF CLAIMS: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

CLAIM FORMS: When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

PROOF OF LOSS: We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

PAYMENT OF CLAIMS: Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

GENERAL POLICY PROVISIONS CONTINUED

OTHER INSURANCE WITH US: You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

PHYSICAL EXAMINATIONS: At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

LEGAL ACTION: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted there from.

CONFORMITY WITH STATE LAWS: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

ASSIGNMENT: No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

CLERICAL ERROR: Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

PRO RATA REFUND: If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

This Policy is signed for Family Life Insurance Company by its President.

Dan George — President

Mary Lou Rainey — Secretary

FAMILY LIFE INSURANCE COMPANY

Home Office: Houston, TX **Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408**

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICATION #:

APPLICANT	**RESIDENCE ADDRESS**
Last *First* *MI*	*Street:*
Check the Medicare Supplement Plan You Prefer:	*City:*
☐ **Standardized Plan A** ☐ **Standardized Plan F**	
☐ **Standardized Plan B** ☐ **Standardized Plan G**	
☐ **Standardized Plan C** ☐ **Standardized Plan M**	*State:* *Zip Code:*
☐ **Standardized Plan D** ☐ **Standardized Plan N**	

MEDICARE INFORMATION	**MAILING ADDRESS**
Date first enrolled in Medicare Part B:_____	*Street:*
Medicare Claim Number: _____	*City:*
(Please include Alpha Character)	*State:* *Zip Code:*

AGE	**DATE OF BIRTH**			**SEX**
	Month	*Day*	*Year*	☐ Male ☐ Female
SOCIAL SECURITY NUMBER				

AREA CODE	**TELEPHONE NUMBER**
HEIGHT	**WEIGHT**
Feet **Inches**	**Lbs.**

Effective Date:	***Special Requests:***

SPOUSE	**Spouse's Medicare Claim Number:**
Last *First* *MI*	

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past five years?

☐ Yes ☐ No

(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

MODAL PREMIUM: **$** _____

SPOUSAL DISCOUNT: **$** _____
(IF APPLICABLE)

POLICY FEE: **$**_____

TOTAL INITIAL PREMIUM: **$** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-14, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.

1.	Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period?	☐ Yes	☐ No
2.	Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
3.	In the past two years, has surgery or tests been advised by a physician but not performed?	☐ Yes	☐ No
4.	Is surgery anticipated in the next twelve months?	☐ Yes	☐ No
5.	Within the past two years have you had an amputation caused by disease?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

6.	Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:		
	a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, or any other cognitive disorder?	☐ Yes	☐ No
	b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?	☐ Yes	☐ No
	c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?	☐ Yes	☐ No
	d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?	☐ Yes	☐ No
	e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?	☐ Yes	☐ No
	f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?	☐ Yes	☐ No
7.	Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?	☐ Yes	☐ No
8.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?	☐ Yes	☐ No
9.	Have you had an organ transplant or been advised to have an organ transplant?	☐ Yes	☐ No
10.	Are you currently using the services of a home health care agency?	☐ Yes	☐ No
11.	Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?	☐ Yes	☐ No
12.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?	☐ Yes	☐ No
13.	Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?	☐ Yes	☐ No
14.	Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with more than two medications?	☐ Yes	☐ No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary. ☐ Yes ☐ No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	**Diagnosis/Onset Date

**** PLEASE DO NOT LIST WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER AS THESE ARE NOT MEDICAL CONDITIONS AND WILL REQUIRE A TELEPHONE INTERVIEW.**

Primary Physician Information

Name:

Address:

Telephone:

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No If yes, what is the effective date? _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

   IF YES,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, with what company, what kind of policy and reason for termination?

   _____

   (b) What are your dates of coverage under the other policy? START __/__/__ END __/__/__

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or

(g) Lost eligibility for health benefits under Medicaid.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent's Signature:	**Date:**
Agent's Printed Name:	**Agent No.:**

AUTHORIZATION

IN FAVOR OF: **Family Life Insurance Company**

Administrative office **P.O. Box 924408, Houston, Texas 77292-4408**

Name of Bank Customer: _____ **Policy Numbers**

Insured's Name: _____

Account Number : **Routing Number:** ☐ **Checking** ☐ **Savings**

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Depositor**

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

AUTHORIZATION

To: **The Bank above**

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

(Attach Voided Check)

AUTHORITY TO HONOR PREMIUM CHECKS

FAMILY LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, B, C, D, F, G, M AND N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Family Life Insurance Company offers six of the fourteen plans available.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*		Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

***Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

FAMILY LIFE INSURANCE COMPANY

PREFERRED PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES
722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,293]	[1,574]	[1,824]	[1,650]	[1,866]	[1,658]	[1,485]	[1,306]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[646.50]	[787.00]	[912.00]	[825.00]	[933.00]	[829.00]	[742.50]	[653.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[323.25]	[393.50]	[456.00]	[412.50]	[466.50]	[414.50]	[371.25]	[326.50]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[53.88]	[65.58]	[76.00]	[68.75]	[77.75]	[69.08]	[61.88]	[54.42]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

STANDARD PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES
722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,437]	[1,748]	[2,026]	[1,832]	[2,074]	[1,843]	[1,649]	[1,452]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[718.50]	[874.00]	[1,013.00]	[916.00]	[1,037.00]	[921.50]	[824.50]	[726.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[359.25]	[437.00]	[506.50]	[458.00]	[518.50]	[460.75]	[412.25]	[363.00]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[59.88]	[72.83]	[84.42]	[76.33]	[86.42]	[76.79]	[68.71]	[60.50]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

PREFERRED PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 AND 721 EXCEPT 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,228]	[1,495]	[1,733]	[1,568]	[1,773]	[1,575]	[1,411]	[1,241]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[614.00]	[747.50]	[866.50]	[784.00]	[886.50]	[787.50]	[705.50]	[620.50]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[307.00]	[373.75]	[433.25]	[392.00]	[443.25]	[393.75]	[352.75]	[310.25]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[51.17]	[62.29]	[72.21]	[65.33]	[73.88]	[65.63]	[58.79]	[51.71]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

STANDARD PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 AND 721 EXCEPT 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,365]	[1,661]	[1,925]	[1,740]	[1,970]	[1,751]	[1,567]	[1,379]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[682.50]	[830.50]	[962.50]	[670.00]	[985.00]	[875.50]	[783.50]	[689.50]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[341.25]	[415.25]	[481.25]	[435.00]	[492.50]	[437.75]	[391.75]	[344.75]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[56.88]	[69.21]	[80.21]	[72.50]	[82.08]	[72.96]	[65.29]	[57.46]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

PREFERRED PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 720-722

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,099]	[1,338]	[1,550]	[1,403]	[1,586]	[1,409]	[1,262]	[1,110]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[549.50]	[669.00]	[775.00]	[701.50]	[793.00]	[704.50]	[631.00]	[555.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[274.75]	[334.50]	[387.50]	[350.75]	[396.50]	[352.25]	[315.50]	[277.50]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[45.79]	[55.75]	[64.58]	[58.46]	[66.08]	[58.71]	[52.58]	[46.25]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

STANDARD PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 720-722

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,221]	[1,486]	[1,722]	[1,557]	[1,763]	[1,567]	[1,402]	[1,234]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[610.50]	[743.00]	[861.00]	[778.50]	[881.50]	[783.50]	[701.00]	[617.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[302.25]	[371.50]	[430.50]	[389.25]	[440.75]	[391.75]	[350.50]	[308.50]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[50.88]	[61.92]	[71.75]	[64.88]	[73.46]	[65.29]	[58.42]	[51.42]

Spousal Discount Factor: .93

PREMIUM INFORMATION

Family Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as state and zip code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]**

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Family Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Family Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

This policy does not contain a pre-existing condition limitation and this policy does not pay benefits for (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section; (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions; (e) Services for which a charge is not normally made in the absence of insurance; or (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $[1100]	$0	[$1100] (Part A deductible)
61st thru 90th day	All but $[275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$550] (50% Part A deductible)	[$550] (50% Part A deductible)
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First [$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$155] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

FAMILY LIFE
INSURANCE COMPANY

Medicare Supplement Insurance Plans

"Insuring your tomorrow
With star treatment today."

Underwritten by Family Life Insurance Company

Family Life Medicare Supplements

Protection from the Bills Medicare Doesn't Pay

Medicare was never meant to cover all of your doctor and hospital bills. Many people do not realize this and expect them to pay all. Reliance on Medicare in this situation can mean financial difficulty with out-of-pocket expenses.

Initial Hospital Deductible

Medicare Part A hospital deductibles have risen $[XXXX] since 1968 - just [XX] years!

$ 40
1968

$[XXXX]

[X X X X]

Family Life Offers 8 Standardized Insurance Plans

Family Life insurance plans are designed to give you choices. Choices you need to help cover health care costs today! Our plans allow you to choose a Medicare Supplement to suit your life's situation, budget and needs. All plans may not be available in all states.

All Medicare Supplement Plans Offer These Benefits:

Part A Co-Insurance pays if you are confined to a hospital. Should you require more than 60 continuous days hospitalization, Family Life will pay the co-insurance amounts up to the 150th day of confinement and also for the first 3 pints of blood each year. Additionally, if you use your lifetime reserve days, Family Life will provide coverage for up to an additional 365 days.

Part B Co-Insurance pays the Medicare Part B coinsurance amount, reducing your out-of-pocket expenses when you require medical services. Plan N requires a copayment of up to $20 for an office visit, and up to $50 copayment for the emergency room.

FAMILY LIFE
INSURANCE COMPANY

FLBRA 4-10

Your Family Life Benefits

Medicare Part A Hospital Coverage

Deductible - Family Life Plans B, C, D, F, G and N all pay the $[XXXX] inpatient hospital deductible for each benefit period. Plan M pays 50% of the Part A Deductible.

First 60 Days - After the Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semiprivate room and board, general nursing and miscellaneous hospital services and supplies.

Coinsurance - All Family Life Plans pay up to $[XXX] a day when you're hospitalized from the 61st through the 90th day. And when you're in the hospital from the 91st through 150th day, Family Life Plans pay you up to $[XXX] a day for each Lifetime Reserve day used.

Extended Hospital Coverage - When you're in the hospital longer than 150 days during a Benefit Period, and you've exhausted your 60 Medicare Lifetime Reserve days, all Family Life Plans pay the Part A Medicare eligible expenses for hospitalization, paid at the Prospective Payment System (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for Blood - Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. All Family Life Plans pay this deductible.

Skilled Nursing Facility Care

First 20 Days - Medicare pays all eligible expenses.

Coinsurance - Family Life Plans C, D, F, G, M and N pay up to $[XXX.XX] a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice Care - After you meet Medicare's requirements, including a doctor's certification of terminal illness, Medicare pays all but very limited co-payment or coinsurance for outpatient drugs and inpatient respite care. Family Life Plans pay the Medicare co-payment or coinsurance.

FAMILY LIFE INSURANCE COMPANY

Medicare Part B
Physician's Services and Supplies

Deductible - Family Life Plans C and F pay the $[XXX.XX] calendar year deductible.

Coinsurance - After the Part B deductible, All Family Life Plans generally pay 20% of Medicare Eligible Expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service. Plan N requires the insured to pay a portion of Part B coinsurance or co-payments: up to $20 copayment for each covered office visit, including specialists, and up to $50 copayment for each covered Emergency Room visit. Emergency Room co-payment will be waived if admitted to any Hospital and the ER visit is covered as a Part A Expense.

Excess Benefits - Your bill for Part B services and supplies may exceed the Medicare Eligible Expense. When that occurs, Family Life Plans F and G pay 100% of the difference, up to the charge limitation established by Medicare.

Benefit for Blood - Medicare has one calendar year deductible for blood that is the cost of the first three pints needed. All Family Life Plans pay this deductible.

Additional Benefits

Emergency Care Received Outside the U.S. - After you pay a $250 calendar-year deductible, Family Life Plans C, D, F, G, M and N pay you 80% of eligible expenses incurred during the first 60 days for emergency care received outside the U.S. up to a lifetime maximum of $50,000. Benefits are payable for emergency health care you need immediately because of a covered injury or illness of sudden and unexpected onset.

Your Plan; The Facts

Family Life helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and Family Life pay.**

Medicare Part A Eligible Expenses for Hospital/ Skilled Nursing Facility Care include expenses for semiprivate room and board, general nursing, miscellaneous services and supplies.

Medicare Part B Eligible Expenses for Medical Services include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

A Benefit Period begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

Coinsurance is the portion of the Medicare Eligible Expense you have to pay. It does not include Part A and B deductible amounts not paid by Medicare.

As Medicare deductibles and coinsurance increase, your Family Life benefits will automatically increase. Family Life benefits will not duplicate benefits paid by Medicare.

Benefits are paid to you or to your hospital or doctor.

You have 31 days from your renewal date to pay your premium. Your policy will stay in force during this 31 day grace period.

Your policy is guaranteed renewable. Your policy cannot be cancelled. It will be renewed as long as the premiums are paid on time.

Rates are based on your age and your premiums will increase automatically on each policy anniversary date, based on the age you attain. Premium rate adjustments may also be made based on current health care cost experience for benefits paid. Family Life reserves the right to establish new premium rates for all insureds based on a class basis, but only after giving you advance notice. **However, we will not increase premiums based on your own claims.**

You're covered immediately. There is no waiting period for pre-existing conditions. Benefits will be paid from the time your policy is in force.

Family Life Medicare Supplements will not pay for:

- Expenses incurred while the policy is not in force except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while the policy is not in force;
- That portion of any expense incurred which is paid for by Medicare;
- Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refreactions;
- Services for which a charge is not normally made in the absence of insurance; or
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

THIS IS A BRIEF DESCRIPTION of your coverage. For complete information on benefits, exceptions and limitations, **PLEASE READ YOUR ACCOMPANYING OUTLINE OF COVERAGE.**

Neither Family Life nor its agents are connected in any way with the Federal or state Government or Medicare.

A Plan to Meet Your Every Need

	Medicare Pays	Plan A Pays	Plan B Pays	Plan C Pays	Plan D Pays	Plan F Pays	Plan G Pays	Plan M Pays	Plan N Pays
Medicare Part A Hospital Coverage									
Deductible	All but $[XXXX]	-	$[XXXX]	$[XXXX]	$[XXXX]	$[XXXX]	$[XXXX]	50% of Deductible	$[XXXX]
First 60 days	100%	-	-	-	-	-	-	-	-
Coinsurance 61-90 days	All but $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]
Coinsurance 91-150 days	All but $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]	Up to $[XXX]
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	-	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood First Three Pints Addtl. Amounts	$0 100%	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -
Hospice Care	All but very limited co-payment / coinsurance for outpatient drugs & inpatient respite care	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance	Medicare Co-payment / coinsurance
Skilled Nursing Facility Care									
First 20 days	100%	-	-	-	-	-	-	-	-
Coinsurance 21-100 days	All but $[XXX] A day	-	-	Up to $[XXX] A day	Up to $[XXX] A day	Up to $[XXX] A day	Up to $[XXX] A day	Up to $[XXX] A day	Up to $[XXX] A day
Medicare Part B Physician's Services and Supplies									
Deductible	-	-	-	$[XXX]	-	$[XXX]	-	-	-
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	- Up to $20 copayment for office visit -Up to $50 copayment for ER
Excess Benefits	-	-	-	-	-	100% up to Medicare's Limit	100% up to Medicare's Limit	-	-
Benefit for Blood First Three Pints Addtl. Amounts	$0 100%	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -	Three pints -
Additional Benefits									
Emergency Care Received Outside The U.S.	-	-	-	Up to $50,000	Up to $50,000	Up to $50,000	Up to $50,000	Up to $50,000	Up to $50,000

FOR CLAIMS, PLEASE CALL:
1-800-877-7703

This brochure is an illustration, not a contract. Consult your outline of coverage for a complete description of benefits available to you.

RECEIPT

Received of _____

this _____ day of _____ the sum of $_____

being the payment of _____ Premium.

This insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the Applicant will be returned.

_____

Agent's Signature

Make checks payable to Family Life Insurance Company.
Do not make payable to agent or leave payee blank.

Underwritten by:
Family Life Insurance Company
10700 Northwest Freeway
Houston, Texas 77092
1-800-877-7703

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 06/01/2010	AR Rates	MSIAM201006AR, MSIAN201006AR	New		AR Rates.pdf

EXHIBIT A

Gross Annual Premiums

FAMILY LIFE INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan M

Issue Age	Preferred	Standard
All	1,485	1,649

There is no modal loading.
A discount factor of 0.93 is applied for married applicants.

Area Factors:

Arkansas	
722……	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199…….	1.00
All other zip codes beginning with 720 and 721…….	0.95
Rest of State……	0.85

EXHIBIT A

Gross Annual Premiums

FAMILY LIFE INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan N

Issue Age	Preferred	Standard
All	1,306	1,452

There is no modal loading.
A discount factor of 0.93 is applied for married applicants.

Area Factors:

Arkansas	
722……	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199…….	1.00
All other zip codes beginning with 720 and 721……	0.95
Rest of State……	0.85

SERFF Tracking Number:	*WAKE-126646836*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*45823*
Company Tracking Number:	*AMHFLMSMN2010AR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.010 Plan M 2010*
Product Name:	*2010 Medicare Supplement Plans M & N*		
Project Name/Number:	*Family Life/AMHFLMSMNAR*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	06/01/2010

Comments:
Attachment:
AR Readability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	06/01/2010

Comments:
Attachment:
MSAPP201004 AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	06/01/2010

Comments:
Attachment:
MSOCI201007 AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter	Accepted for Informational Purposes	06/01/2010

Comments:
Attachment:
FLIC Authorization.pdf

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

Family Life Insurance Company
P.O. Box 924408
Houston, Texas 77292-4408

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Medicare Supplement Policy – Plan M	MSAAA201006 AR	49.2
Medicare Supplement Policy – Plan N	MSAAB201006 AR	49.3
Outline of Coverage	MSOCA201006R AR	41.3
Application	MSAPP201004 AR	44.0
Advertising Brochure	FLBRA 4-10	40.6

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

Michelle Miller
Digitally signed by Michelle Miller
DN: cn=Michelle Miller, o=Hess Compliance Consulting, ou=Compliance, email=Michelle.Miller@hesscc.com, c=US
Date: 2010.05.26 23:37:20 -04'00'

Signature

Michelle Miller
Name

Compliance Consultant
Title

FAMILY LIFE INSURANCE COMPANY

Home Office: Houston, TX **Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408**

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICATION #:

APPLICANT

Last *First* *MI*

Check the Medicare Supplement Plan You Prefer:

- ☐ **Standardized Plan A**
- ☐ **Standardized Plan B**
- ☐ **Standardized Plan C**
- ☐ **Standardized Plan D**
- ☐ **Standardized Plan F**
- ☐ **Standardized Plan G**
- ☐ **Standardized Plan M**
- ☐ **Standardized Plan N**

RESIDENCE ADDRESS

Street:

City:

State: *Zip Code:*

MEDICARE INFORMATION

Date first enrolled in Medicare Part B:_____

Medicare Claim Number: _____

(Please include Alpha Character)

MAILING ADDRESS

Street:

City:

State: *Zip Code:*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

AREA CODE	TELEPHONE NUMBER

HEIGHT	WEIGHT
Feet **Inches**	**Lbs.**

Effective Date:

Special Requests:

SPOUSE

Last *First* *MI*

Spouse's Medicare Claim Number:

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past five years?

☐ Yes ☐ No

(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

MODAL PREMIUM: **$** _____

SPOUSAL DISCOUNT: **$** _____
(IF APPLICABLE)

POLICY FEE: **$**_____

TOTAL INITIAL PREMIUM: **$** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-14, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.

1.	Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period?	☐ Yes	☐ No
2.	Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
3.	In the past two years, has surgery or tests been advised by a physician but not performed?	☐ Yes	☐ No
4.	Is surgery anticipated in the next twelve months?	☐ Yes	☐ No
5.	Within the past two years have you had an amputation caused by disease?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

6.	Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:		
	a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, or any other cognitive disorder?	☐ Yes	☐ No
	b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?	☐ Yes	☐ No
	c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?	☐ Yes	☐ No
	d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?	☐ Yes	☐ No
	e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?	☐ Yes	☐ No
	f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?	☐ Yes	☐ No
7.	Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?	☐ Yes	☐ No
8.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?	☐ Yes	☐ No
9.	Have you had an organ transplant or been advised to have an organ transplant?	☐ Yes	☐ No
10.	Are you currently using the services of a home health care agency?	☐ Yes	☐ No
11.	Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?	☐ Yes	☐ No
12.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?	☐ Yes	☐ No
13.	Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?	☐ Yes	☐ No
14.	Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with more than two medications?	☐ Yes	☐ No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary. ☐ Yes ☐ No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	**Diagnosis/Onset Date

**** PLEASE DO NOT LIST WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER AS THESE ARE NOT MEDICAL CONDITIONS AND WILL REQUIRE A TELEPHONE INTERVIEW.**

Primary Physician Information

Name:

Address:

Telephone:

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No If yes, what is the effective date? _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.
   IF YES,
   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No
2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No
3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
   (b) If so, with which company: _____
   with which plan: _____
   and what paid-to-date do you have? _____
   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No
   (a) If yes, with what company, what kind of policy and reason for termination?
   _____
   (b) What are your dates of coverage under the other policy? START __/__/__ END __/__/__

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or

(g) Lost eligibility for health benefits under Medicaid.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent's Signature:	**Date:**
Agent's Printed Name:	**Agent No.:**

AUTHORIZATION

IN FAVOR OF: **Family Life Insurance Company**

Administrative office **P.O. Box 924408, Houston, Texas 77292-4408**

Name of Bank Customer: _____ **Policy Numbers**

Insured's Name: _____

Account Number : **Routing Number:** ☐ **Checking** ☐ **Savings**

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Depositor**

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

AUTHORIZATION

To: **The Bank above**

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

(Attach Voided Check)

AUTHORITY TO HONOR PREMIUM CHECKS

FAMILY LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, B, C, D, F, G, M AND N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Family Life Insurance Company offers six of the fourteen plans available.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*		Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

***Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

FAMILY LIFE INSURANCE COMPANY

PREFERRED PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES
722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,293]	[1,574]	[1,824]	[1,650]	[1,866]	[1,658]	[1,485]	[1,306]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[646.50]	[787.00]	[912.00]	[825.00]	[933.00]	[829.00]	[742.50]	[653.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[323.25]	[393.50]	[456.00]	[412.50]	[466.50]	[414.50]	[371.25]	[326.50]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[53.88]	[65.58]	[76.00]	[68.75]	[77.75]	[69.08]	[61.88]	[54.42]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

STANDARD PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES
722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,437]	[1,748]	[2,026]	[1,832]	[2,074]	[1,843]	[1,649]	[1,452]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[718.50]	[874.00]	[1,013.00]	[916.00]	[1,037.00]	[921.50]	[824.50]	[726.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[359.25]	[437.00]	[506.50]	[458.00]	[518.50]	[460.75]	[412.25]	[363.00]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[59.88]	[72.83]	[84.42]	[76.33]	[86.42]	[76.79]	[68.71]	[60.50]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

PREFERRED PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 AND 721 EXCEPT 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,228]	[1,495]	[1,733]	[1,568]	[1,773]	[1,575]	[1,411]	[1,241]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[614.00]	[747.50]	[866.50]	[784.00]	[886.50]	[787.50]	[705.50]	[620.50]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[307.00]	[373.75]	[433.25]	[392.00]	[443.25]	[393.75]	[352.75]	[310.25]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[51.17]	[62.29]	[72.21]	[65.33]	[73.88]	[65.63]	[58.79]	[51.71]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

STANDARD PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 AND 721 EXCEPT 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,365]	[1,661]	[1,925]	[1,740]	[1,970]	[1,751]	[1,567]	[1,379]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[682.50]	[830.50]	[962.50]	[670.00]	[985.00]	[875.50]	[783.50]	[689.50]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[341.25]	[415.25]	[481.25]	[435.00]	[492.50]	[437.75]	[391.75]	[344.75]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[56.88]	[69.21]	[80.21]	[72.50]	[82.08]	[72.96]	[65.29]	[57.46]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

PREFERRED PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 720-722

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,099]	[1,338]	[1,550]	[1,403]	[1,586]	[1,409]	[1,262]	[1,110]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[549.50]	[669.00]	[775.00]	[701.50]	[793.00]	[704.50]	[631.00]	[555.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[274.75]	[334.50]	[387.50]	[350.75]	[396.50]	[352.25]	[315.50]	[277.50]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[45.79]	[55.75]	[64.58]	[58.46]	[66.08]	[58.71]	[52.58]	[46.25]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY

STANDARD PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 720-722

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[1,221]	[1,486]	[1,722]	[1,557]	[1,763]	[1,567]	[1,402]	[1,234]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[610.50]	[743.00]	[861.00]	[778.50]	[881.50]	[783.50]	[701.00]	[617.00]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[302.25]	[371.50]	[430.50]	[389.25]	[440.75]	[391.75]	[350.50]	[308.50]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
All Ages	[50.88]	[61.92]	[71.75]	[64.88]	[73.46]	[65.29]	[58.42]	[51.42]

Spousal Discount Factor: .93

PREMIUM INFORMATION

Family Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as state and zip code of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]**

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Family Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Family Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

This policy does not contain a pre-existing condition limitation and this policy does not pay benefits for (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section; (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions; (e) Services for which a charge is not normally made in the absence of insurance; or (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $[1100]	$0	[$1100] (Part A deductible)
61st thru 90th day	All but $[275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$550] (50% Part A deductible)	[$550] (50% Part A deductible)
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First [$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 [$155] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

FAMILY LIFE

Daniel George
President

December 14, 2009

To Whom It May Concern:

The firm of Wakely Actuarial Services, Inc., located at 34125 US Highway 19 North, Suite 310, Palm Harbor, Florida 34684, is hereby authorized to submit form filings for approval on behalf of Family Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Family Life Insurance Company.

Sincerely,

Daniel J. George

Family Life Insurance Company
Wortham Tower
2727 Allen Parkway, Suite 500
Houston, TX 77019-2115

Phone: 713-821-6475
Toll Free: 800-669-9030 x 6475
Fax: 713-529-9425
dgeorge@manhattanlife.com

MANHATTAN INSURANCE GROUP